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The Process and Implications of Self-Stigma in Schizophrenia

Deborah E. Ward
Psychology

Despite increased understanding of the diagnosis and treatment of mental health disorders, misperceptions about these disorders persist, leading to stigma and discrimination toward those who live with them. For the purposes of this article, *stigma* refers to the devaluation of certain persons on the basis of some characteristic they possess, such as possession of a mental health disorder diagnosis. When an individual living with mental illness endorses the discriminatory beliefs regarding their specific disorder and applies it to their self, they are engaging in *self-stigma* (Corrigan & Watson, 2002). Self-stigma can lead to a variety of negative outcomes, including diminished self-esteem and failure to adhere to treatment programs, leading to poor prognosis (Link, 1982; Ritscher & Phelan, 2004; Corrigan, Watson, & Barr, 2006; Yap, Wright, & Jorm, 2011).

Perhaps the most widely stigmatized mental disorder is schizophrenia. Affecting about 1% of the United States adult population, schizophrenia is a chronic mental disorder characterized by maladaptive thought patterns and poor emotional responses (American Psychiatric Association, 2000). Common symptoms of schizophrenia include delusions, such as paranoia; hallucinations, such as hearing voices that are not there; disorganized or illogical patterns of thought; lack of emotion; and lack of motivation. Individuals with schizophrenia are often portrayed in media sources ranging from newspapers to feature films as burdens on society and dangers to others (Baker, 2012). In popular culture, the term "schizophrenic" has become a synonym for "crazy," "weird," "dangerous," and even "unfashionable" (Tripoli, 2012**;** Baker, 2012). The following review will examine how stigma and self-stigma are propagated as well as the effects of self-stigma on individuals diagnosed with schizophrenia.

What is Stigma?

The term "stigma" derives from the historical practice of physically branding members of devalued groups so that they carried a visible sign of disgrace. The

marks signaled the flawed, deviant nature of their bearers, allowing all of society to know the individual's degraded status (e.g., Goffman, 1963; Hinshaw, 2007). Hinshaw (2007) construes the process of stigmatization as a typically social one. People tend to think in terms of categories, forming clusters of related experiences to simplify the environment and allow for quick comprehension of situations (Allport, 1954). This cluster formation extends to groups of people as well, and humans will even classify themselves as belonging to particular groups (e.g. college students, Pennsylvanians, Asian-Americans). Prejudice, or a general negative affect directed towards a person or group, can occur when a perceiver identifies some characteristic as suggestive of membership in an out-group, a group to which the perceiver him or herself does not belong (Allport, 1954). Intense devaluation of the characteristic, resulting from this general negative feeling towards the out-group identity with which the characteristic is associated, changes recognition of a characteristic into stigmatization of the out-group as a whole (e.g., Goffman, 1963; Hinshaw, 2007).

Most stigma scholars regard stigma as a social construction, a label attached by society (Major & O‘Brien, 2005). The process by which stigma develops suggests that a devalued attribute becomes associated with negative evaluations and stereotypes, and these evaluations and stereotypes are generally widely shared and well-known among members of a culture (Crocker et al., 1998). The devalued attribute then becomes a basis for excluding or avoiding members who possess it (Allport, 1954; Major & O‘Brien, 2005). For widespread stigmatization of a particular characteristic to occur, those who deem the characteristic undesirable must be able to exert social influence (Hinshaw, 2007). Both powerful and powerless groups may stereotype and negatively evaluate others but, because powerful groups control access to resources, their beliefs are more likely to persist (Allport, 1954; Fiske, 1993; Link & Phelan, 2001). When power shifts occur, formerly stigmatized traits and attributes can be upgraded in status, indicating malleability in the stigma process (Hinshaw, 2007).

Stigma in Society

It is important to recognize that individuals who are stigmatized live in the same society as those who stigmatize them. This means that stigmatized individuals tend to share the same world-view and hold the same beliefs of what is “good“ or “bad” and “right“ or “wrong” as those who stigmatize them. Erving Goffman, one of the first scholars to define the concept of stigma, wrote:

> The stigmatized individual tends to hold the same beliefs about identity that [non- stigmatized persons] do: this is a pivotal fact . . . . The standards he

> has incorporated from the wider society equip him to be intimately alive to what others see as his failing . . . . Shame becomes a central possibility, arising from the individual's perception of one of his own attributes as being a defiling thing to possess. (Goffman, 1963, p 7)

Or, as Hinshaw (2007) phrased it, "demeaning attitudes of perceivers may come to be internalized by the possessor of the devalued attribute in question" (p 25). Further, because of associative linkages in memory between stereotypes and the behaviors they imply, activation of stereotypes can automatically lead to behavior that assimilates to the stereotype (Major & O'Brien, 2005). For example, consistent with stereotypes about mathematical ability, Asian-American women who were primed with their Asian identity produced superior performance on a math test whereas participants primed with their female identity produced decreased performance relative to women in a control group (Shih, Ambady, Richeson, Fujita, & Heather, 2002). Common stereotypes about people with mental illness include that they are dangerous, incompetent, and to blame for their illness (Corrigan & Kleinlein, 2005). When individuals face the onset of a mental illness, such as schizophrenia, these stereotypes become relevant to the self.

One recent study suggests that the general public's understanding of the causes of mental illness has broadened in the past 30 years (Link & Phelan, 2001). One would hope this means that stigma is "becoming a thing of the past" (Corrigan & Watson, 2002, p 36), however, the same study showed that attitudes about persons with mental illness have become *more* stigmatizing, particularly in terms of perceptions of danger (Link & Phelan, 2001). Research performed with English and American citizens identify three common prejudices regarding persons with mental illness: 1) persons with severe mental illness should be feared and, therefore, be kept out of most communities; 2) persons with severe mental illness are irresponsible, so their life decisions should be made by others; and 3) persons with severe mental illness are childlike and need to be cared for (Link & Phelan, 2001). Individuals with mental illness may agree with and internalize these prejudices as well as prejudices regarding their specific disorder. This process is known as self-stigma.

Self-Stigma

Self-stigma is defined as the devaluation of the self as a result of internalizing a stigmatized identity associated with the negative stereotypes about one's social group (Corrigan, Larson, & Rusch, 2009). Long-standing theories have represented self-stigma as the automatic result of being a member of a stigmatized group (Allport, 1954; Corrigan & Watson, 2002). However, not everyone who

experiences stigma necessarily experiences negative effects, such as diminished self-esteem or self-efficacy (Corrigan & Watson, 2002; Watson, Corrigan, Larson & Sells, 2007). Some people react to stigma by becoming energized and empowered; others remain relatively indifferent and unaffected (Corrigan & Watson, 2002; Watson, Corrigan, Larson & Sells, 2007). Many individuals who can be categorized as a member of a stigmatized group (e.g. overweight, mentally ill) are aware of the stereotypes that exist regarding their group. The awareness of stigma is not necessarily synonymous with internalizing it (Corrigan & Watson, 2002).

Corrigan and Watson (2002) have created a model to define the parameters of self-stigma, offering an explanation as to how one person comes to internalize stigma as self-stigma while another might not. For example, many persons with mental illness report being aware of the negative stereotypes about them but do not necessarily agree with these stereotypes (Corrigan & Watson, 2002). The authors argue that being aware of potential discrimination and prejudice does not cause self-stigma; *stigma awareness* is a necessary, but not sufficient, component of self-stigma. *Stereotype agreement* is another necessary component for self-stigma, and this occurs when an individual agrees with the common public prejudices. The process becomes self-stigmatizing with the addition of *stereotype self-concurrence*, in which an individual applies the culturally internalized beliefs to him or herself (Corrigan & Watson, 2002).

The Effects of Self-Stigma

Research suggests that people who endorse self-stigma are more likely to report diminishment in self-esteem and self-efficacy (Watson et al., 2007; Corrigan et al., 2006; Yap et al., 2011; Ritsher & Phelan, 2004). Ritsher and Phelan (2004) surveyed outpatients with a "serious mental illness" (defined as a diagnosis of schizophrenia, psychosis, depression, and/or PTSD). Their goal was to determine whether internalized stigma and perceived devaluation and discrimination predicted deteriorations in self-esteem and depressive symptoms over a four-month time span.

Internalized stigma in general was common amongst participants and high levels of internalized stigma at baseline were associated with more depressive symptoms and lower self-esteem at a follow-up four months later (Ritsher & Phelan, 2004). More specifically, individuals who expressed experiencing alienation, stereotype endorsement, and social withdrawal were more likely to have symptoms of depression and lower levels of self-esteem at their four month follow up. Corresponding with Corrigan and Watson's (2002) model, perceptions of current discrimination did not predict reduction in self-esteem or increase in

depressive symptoms (Ritsher & Phelan, 2004). Only when stigma was applied to the self did it have an impact on self-esteem (Ritscher & Phelan, 2004; Corrigan et al., 2006).

Findings from an additional study by Corrigan et al. (2006) indicated that diminishment in self-esteem and self-efficacy results from self-stigma (regarding mental illness). Created for this study, the Self-Stigma of Mental Illness Scale (SSMIS) assesses participants' *awareness* of stigma, *agreement* with stigma, *application* of stigma to the self, and stigma's *harm to self-esteem* (Corrigan et al., 2006; Corrigan, Michaels, Vega, Gause, Watson, & Rusch, 2012). Stereotype agreement was significantly associated with self-concurrence and self-esteem decrement, and this occurs because stereotype agreement is primary to self-concurrence. A person has to agree with a stereotype before they apply it to him or herself (Corrigan et al, 2006). Self-esteem and self-efficacy were not found to be significantly associated with stereotype agreement, indicating that just because people endorse stigma of a mental illness does not mean they will internalize it and suffer diminished self-esteem and self-efficacy as a result (Corrigan et al., 2006).

In addition to diminishment in self-esteem and self-efficacy, research suggests that people who endorse self-stigma are more likely to limit their prospects for recovery (Watson et al., 2007; Yap, Wright, & Jorm, 2011; Corrigan, Larson & Rusch, 2009). Limiting of prospects includes not seeking treatment and not adhering to prescribed treatments. Self-stigma may undermine adherence to empirically validated services (Golberstein, Eisenberg, & Gollust, 2008; Yap et al., 2011) as well as interfere with pursuit of rehabilitation goals (Link, 1982). For this reason, it is important to examine self-stigma within the context of a specific mental disorder, such as schizophrenia.

Schizophrenia

As stated previously, schizophrenia is a chronic mental disorder characterized by maladaptive thought patterns and poor emotional responses (American Psychiatric Association, 2000). Schizophrenia is the most debilitating and costly of all adult psychiatric illnesses (Combs, Mueser & Gutierrez, 2012). Roughly $22.7 billion of the U.S. dollars spent on schizophrenia is directed to treatment and medical needs, yet the impact on a person's social and occupational functioning may be even more devastating (Combs, Mueser & Gutierrez, 2012). Schizophrenia is characterized by impairments in social functioning, including difficulty establishing and maintaining interpersonal relationships, problems working or going to school, and difficulties caring for one-self. Additionally, individuals with schizophrenia can experience a wide range of cognitive symptoms, including hallucinations, delusions, thought disorganization, apathy, and difficulty with memory as well as

depression and anxiety (Combs et al., 2012). The prognosis of schizophrenia is generally poor to fair, and impairments tend to be long term and fluctuate in severity over time. Despite this, research shows that many individuals with schizophrenia can attain symptom remission and recovery with the appropriate pharmacological and psychosocial treatments (Combs et al., 2012).

Around one in three people with a diagnosis of schizophrenia also have a social anxiety disorder. It has been suggested that stigma may be closely related to the social anxiety displayed within so many individuals diagnosed with schizophrenia (van Zelst, 2009). Presence of social anxiety is predicted by greater experience of shame related to diagnosis (van Zelst, 2009). This finding is relevant considering that higher levels of anxiety are associated with a more frequent presence of symptoms, such as hallucinations and depression, as well as poorer function and restricted quality of life. There is also evidence that prejudice and discrimination related to schizophrenia result in an increased probability of misuse of drugs and alcohol (van Zelst, 2009).

Self-Stigma and Schizophrenia Treatment Adherence

Fung, Tsang and Corrigan (2008) examined whether individuals who endorsed self-stigma were more likely to demonstrate poorer health-seeking behaviors in terms of treatment participation and attendance. Fung et al. (2008) gathered a sample of approximately 90 participants who had, on average, been living with a diagnosis of schizophrenia for 13 years and currently exhibited many of the socially debilitating symptoms associated with schizophrenia (e.g. hallucinations, delusions, blunt affect). Each participant completed the Psychosocial Treatment Compliance Scale, which assesses the level of adherence a participant pays to their treatment program (PTCS; Tsang, Fung, & Corrigan, 2006). Treatment programs include social skills training, vocational rehabilitation, cognitive behavioral therapy, and family intervention. Participants also completed measures assessing perceived stigma and self-stigma pertaining to mental illness (via the SSMIS) as well as self-esteem (via the Rosenberg Self-Esteem Scale) (RSES; Rosenberg, 1965). Results indicated that better self-esteem and insight regarding the social consequences of mental illness were significant predictors of better psychosocial treatment participation. Higher levels of self-stigma and poorer insight into the social consequences of mental illness were found to be significant predictors of poor psychosocial treatment attendance (Fung et al., 2008). In general, these findings suggest that when people with schizophrenia concur with public stigma and internalize it, they are more likely to show poor adherence to psychosocial treatment. Failure to promote treatment adherence will inhibit treatment outcomes

and act as a barrier for the recovery of people with schizophrenia (Fung et al., 2008; Lysaker, Roe, Ringer, Gilmore & Yanos, 2012).

Fung, Tsang & Cheung (2011) have developed and tested a self-stigma reduction program. Their proposed program contains 16 sessions, including group and individual sessions, which integrate treatment strategies from a variety of modalities: psychoeducation, cognitive behavior therapy, social skills training, and goal attainment. The program was tested on participants who had been diagnosed with schizophrenia and had at least a primary school education (Fung et al., 2011). Findings suggested that the self-stigma reduction program increased self-esteem, facilitated the change of problematic personal behaviors, and enhanced participation in psychosocial treatment programs (Fung et al., 2011). It is important to note, however, that the therapeutic effects of the self-stigma reduction program were not long lasting and could not be maintained after the completion of the program (Fung et al., 2011).

Methodological Issues and Directions for Future Research

Most empirical studies regarding stigma have relied on survey measures as the sole assessment technique. Many of the studies described above even rely on the same exact measures to assess self-stigma. Brohan, Slade, Clement, and Thornicroft (2010) reviewed measures of the three aspects of stigma: perceived stigma (how the individual thinks society views him or her as a member of the stigmatized group), experienced stigma (experience of actual discrimination on the grounds of the stigmatized individual's perceived inferiority), and self-stigma (internalization of the shame, blame, hopelessness, guilt, and fear of discrimination associated with mental illness). Across the 57 papers identified as focusing on these three aspects of stigma, only 14 different scales were used to assess the three types of stigma, and some of these scales did not meet acceptable scores for internal consistency or test-retest reliability. This lack of methodological variability and test validity limit the conclusions that may be drawn from the current body of research. Additionally, perceived stigma was assessed in 79% of the studies, experienced stigma in 46% of the studies, and self-stigma in only 33% of the studies. Given the implications for patients, self-stigma needs to become more of a focus in current research.

At this time, most of the work on the subject of self-stigma has been completed by the same handful of authors. Replications and continuations of this line of research by different groups of researcher will help generate new methodologies, samples, and theories to move the study of self-stigma forward. For example, current studies on self-stigma are largely retrospective and are, therefore, subject to bias and hindsight on the part of participants. The handful of longitudinal studies in publication cover a timespan of less than a year (Rusch,

Corrigan, Todd & Bodenhausen, 2011). Current literature has limited focus on experience of stigma in adolescents and adults. It would be beneficial to begin longitudinal studies and to seek out samples of children with mental disorders in order to more convincingly ascertain the causal aspects of self-stigma.

More recently, there has been publication of research that uses alternative methods of measuring stigma, such as qualitative data and implicit measures (Rusch et al., 2010; Rusch et al., 2011). Rusch et al. (2010) indicated that implicit self-stigma is a measurable construct and is associated with negative outcomes. Continuing this line of work, Rusch et al. (2011) used the lexical decision task (LDT) to assess automatic stereotyping. The LDT focuses on the speed with which respondents can identify particular letter strings as valid words (Wittenbrink, Judd, & Park, 2001). The purpose of the LDT is to determine whether activation of a particular concept (such as "mental illness") will facilitate the identification of stereotypically associated words (such as "dangerous"). Automatic stereotyping, as measured by the LDT, was compared between individuals diagnosed with schizophrenia and individuals with no diagnosis of mental disorder. If individuals with mental illness internalize the views of society at large, they should also engage in automatic stereotyping (Rusch et al., 2011). Rusch et al. (2011) also sought to determine if automatic stereotyping was related to self-reported emotional reactions toward mental illness, such as anger and shame. Results revealed markedly less negative stereotype-specific automatic reactions in individuals with mental illness than in the general public control group. However, greater anger-related prejudice was expressed in individuals with mental illness toward their in-group than was expressed by members of the general public (Rusch et al., 2011). Future research on stigma should continue to use implicit measures in conjunction with the self-report measures most commonly seen.

Among empirical studies of self-stigma reduction strategies, two approaches for self-stigma reduction have emerged: 1) interventions that attempt to alter the stigmatizing beliefs and attitudes of the individual, and 2) interventions that enhance skills for coping with self-stigma through improvements in self-esteem, empowerment, and help-seeking behaviors (Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012). This is a start, but further work is needed in evaluating self-stigma interventions; many of these studies have been exploratory or pilot investigations with limitations such as small sample size, lack of randomization, and no control group (Mittal et al., 2012). Continuing with these types of studies will advance the body of research from describing the phenomena of stigma and self-stigma to refining treatment programs that will aid individuals with schizophrenia and other serious mental illnesses in their rehabilitation.

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